

KAWERAK, INC.

KAWERAK, INC.

Education, Employment, and Supportive Services

P.O. Box 948, Nome, AK 99762

Toll Free: 1-877-759-4362 Phone: 907-443-4349 Fax: 907-443-4465

Email: vr@kawerak.org Website: www.kawerak.org

Vocational Rehabilitation Program Application

The Kawerak Vocational Rehabilitation (KVR) Program assists individuals with disabilities to obtain or retain various forms of employment. This employment can be earned income through an employer, self-employment through a small business, or self-employment through subsistence activities.

Eligibility Criteria

Applicants must have a documented disability (physical or mental impairment) that is a substantial barrier to employment.

Applicants must reside in the Bering Strait Region at the time of application.

Applicants must be at least 16 years of age.

Applicants must be Tribally enrolled in a Tribe that is recognized by the U.S. Federal Government.

Applicants must be able to benefit from vocational rehabilitation services.

Application Process

The following documents or information are required in order to complete the application:

☐ Complete the Vocational Rehabilitation Program Application

☐ Submit Verification of Tribal Enrollment (see your Tribe for assistance)

☐ Submit a copy of your medical or mental health records that describe the functional limitation(s) your impairment(s) cause.

If you are unable to provide these records:

☐ Complete the appropriate Releases of Information (we can assist you with this)

☐ Complete Supplemental Information Forms (if needed)

Case Management & Follow-up

Once the application is complete, the applicant will have to speak with a KVR Counselor to review the application, determine services needed, complete an Individualized Plan for Employment, and participate in carrying out the activities of his or her plan.

*Assistance will vary with each participant and be determined on a case by case basis as outlined in an Individualized Plan for Employment (IPE). Funds cannot be used to pay financial debt.

Kawerak, Inc. Education, Employment & Supportive Service Division

Mailing Address: P.O. Box 948 Nome, AK 99762 ~ **Email:** vr@kawerak.org ~ **Phone:** (907) 443-4349 **Toll Free:** (877) 759-4362 ~ **Fax:** (907) 443-4465

Kawerak Vocational Rehabilitation (KVR) Program Application Page

Name: _____ Current Age _____
 (First) (Middle) (Last) (Also Known As or Maiden name)

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Home Phone: _____ Work / Cell: _____ Email Address: _____

Present Mailing Address: _____
 (Street Address or P.O. Box) (City) (State) (Zip Code)

Veteran? ☐ No ☐ Yes - Date of Discharge: ____/____/____ **Registered with Selective Service?** ☐ Yes ☐ No ☐ N/A

Educational Status:

- ☐ High School Diploma - Year Graduated: _____ ☐ GED - Year Graduated: _____ or ☐ Highest Grade Completed: _____
☐ Vocational Training Graduate - Type of Certificate or Licensure: _____
☐ College Graduate - Type of Degree: ☐ Certification ☐ AA/AAS ☐ BA/BS ☐ MA/MS ☐ Other: _____ Year _____

Most jobs are subject to drug testing. **Are you willing to take a drug test?** ☐ Yes ☐ No

Applicant Goal(s) – Check All That Apply

- ☐ Obtain, Keep, or Advance in a Job
☐ Retain Current Job
☐ Self-employment through a Small Business
☐ Self-employment through Subsistence Activities
☐ Earn a High School Diploma or GED
☐ Earn a College Diploma
☐ Earn a License/Certification through Vocational Training
☐ Obtain Driver's License
☐ Other (Specify): _____

I expect to meet my goal(s) by: ____/____/____

Record of Impairment (Check All That Apply)

You may be eligible for the KVR Program if you have a physical and/or mental impairment that creates a substantial barrier to employment. Records of the *functional limitations* that are caused by your impairment(s) are required before we can determine your eligibility for the program.

A record of my impairment(s) exist at the following locations:

- ☐ Alaska Native Medical Center
☐ Norton Sound Health Corporation
☐ Norton Sound Behavioral Health Services
☐ Bering Straits School District
☐ Nome Public School District
☐ Other (Specify): _____

Applicant Status and Program Enrollment

Applicant Status and Sources of Support

(Check All That Apply)

- ☐ Employed →
☐ Self-Employed
☐ Collecting Unemployment
☐ Serving on Boards/Commissions
☐ Unemployed →
☐ Receiving Social Security Benefits
☐ Receiving Public Assistance
☐ Volunteering
☐ Family/Friends Support

(Must Complete)

Last or Current hourly wage:

\$ _____

Unemployed since:

____/____/____

Tribally Enrolled With...

(Check one or write in "Other")

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Brevig | <input type="checkbox"/> Saint Michael |
| <input type="checkbox"/> Council | <input type="checkbox"/> Savoonga |
| <input type="checkbox"/> Diomed | <input type="checkbox"/> Shaktoolik |
| <input type="checkbox"/> Elim | <input type="checkbox"/> Shishmaref |
| <input type="checkbox"/> Gambell | <input type="checkbox"/> Solomon |
| <input type="checkbox"/> Golovin | <input type="checkbox"/> Stebbins |
| <input type="checkbox"/> King Island | <input type="checkbox"/> Teller |
| <input type="checkbox"/> Koyuk | <input type="checkbox"/> Unalakleet |
| <input type="checkbox"/> Mary's Igloo | <input type="checkbox"/> Wales |
| <input type="checkbox"/> Nome Eskimo | <input type="checkbox"/> White Mountain |
| <input type="checkbox"/> Other: _____ | |

Living Arrangement

(Check one or write in "Other")

- ☐ Private Residence
☐ Pre-maternal Home/Patient Hostel
☐ Group Home (e.g. BSWG, etc.)
☐ Nursing Home
☐ Homeless
☐ Inpatient Treatment Facility
Release date: _____
☐ Correctional Facility (AMCC, Seaside, Nome Youth Facility, etc.)
Release date: _____
☐ Other: _____

I certify that the information given on this application is true to the best of my knowledge. By signing my name, I agree to allow information from this form to be used for reporting and follow-up purposes. I understand that my name will never be used in any report and that all data will be kept strictly confidential.

Print Name: _____ **Signature:** _____ **Date:** _____

Parent or Legal Guardian's Signature (if applicable): _____ **Date:** _____

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Barriers to Employment – Use Additional Pages if Necessary

Dear Applicant,

In order for the Kawerak Vocational Rehabilitation (KVR) Program to begin working with you to determine your eligibility, we will need to know the following:

1. Do you need any accommodations (additional help) to apply for this program? ☐ No ☐ Yes

If yes, please list your needed accommodations here:

2. These are the disabilities that I have...

☐ Physical (List): _____

☐ Mental (List): _____

☐ Learning (List): _____

☐ Chemical Dependency Recovery (List): _____

3. I would like to be employed/maintain employment, but the disabilities that I listed above make it difficult for me to (check all that apply):

☐ Obtain a Job

☐ Keep a Job

☐ Obtain self-employment through a small business

☐ Keep self-employment through a small business

☐ Obtain self-employment through subsistence

☐ Keep self-employment through subsistence

4. This is how my disabilities make it difficult for me to be self-sufficient:

5. There may be additional situational restrictions of the type of work I can do because (check all that apply):

- ☐ I am a single parent of one or more dependent children under the age of 18.
- ☐ My English speaking ability is limited.
- ☐ I have been unemployed for more than 6 months.
- ☐ I do not have my basic needs met.
- ☐ I have other situational issues that my employment plan will need to address. They are:

6. There may be additional legal restrictions on the type of work I can do because (check all that apply):

- ☐ I owe child support arrears.
- ☐ I am currently on probation.
- ☐ I am currently on parole.
- ☐ I have a federal felony conviction.
- ☐ I have a state felony conviction.
- ☐ I have a misdemeanor conviction.
- ☐ I am a convicted sex offender.
- ☐ I have other legal issues that my employment plan will need to address. They are:



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Vocational Rehabilitation Program Participant Rights and Responsibilities

If you are determined eligible, below are your rights and responsibilities for participating in this program.

Your Rights

- ☐ To participate fully in the development of your own Individualized Plan for Employment (IPE).
- ☐ To be treated with dignity.
- ☐ To have your eligibility for services determined within 60 days, unless there are unforeseen circumstances and you agree to extend the time.
- ☐ To receive a fair and complete evaluation to determine your eligibility.
- ☐ To have your records and communication kept confidential. Information will not be released without your written permission, unless under court order.
- ☐ To make informed choices during the time you are participating in the Kawerak Vocational Rehabilitation Program.
- ☐ To appeal the Vocational Rehabilitation decisions through an Informal Review, Mediation, or formal Hearing if necessary.
- ☐ To have access to the Client Assistance Program for problem resolution. (CAP – Counselor)
- ☐ To access and receive services in a barrier free environment, including communication access and written information in an alternate format.
- ☐ To receive appropriate Assistive Technology assessments that lead to employment.

Your Responsibilities

- ☐ To take an active role in the development, implementation and completion of your IPE.
- ☐ To request disability related accommodations you require.
- ☐ To apply for and secure needed sources of funding for which you may be eligible for such as financial aid (scholarships, insurance benefits, other public assistance, etc.)
- ☐ To actively participate and maintain regular contact with your vocational rehabilitation counselor.
- ☐ To talk with your counselor if you are having a problem that is affecting your vocational plan.
- ☐ To actively seek and gain employment.

I have reviewed the above program participant rights and responsibilities. The Kawerak Vocational Rehabilitation Program staff have answered all questions I have about my rights and responsibilities, though I know I may ask questions about my rights or responsibilities at any time while receiving services. I understand that I may request a copy of this from at any time.

Participant Signature

Date

Parent or Legal Guardian's Signature (if applicable)

Date



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Program Participant Satisfaction Form (Informational)

Kawerak Vocational Rehabilitation (KVR) staff are committed to providing professional quality assistance and support to individuals with disabilities in efforts to attain vocational goals.

Program participants are assured that their confidentiality will be maintained in all matters, and a HIPPA Compliant Authorization for the Exchange of Protected Information will be signed before any information is released to a third party.

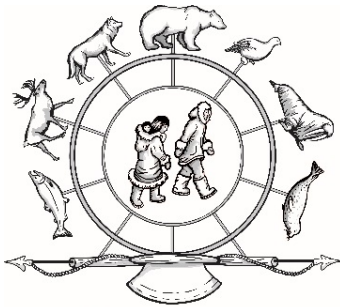
If a program participant believes there is a problem with services received through the KVR Program, the program participant is to report this so that the KVR Program can address the needs of the individual, and investigate the problem to determine ways to improve services for all program participants. All program participant complaints will be investigated as objectively and fairly as possible by seeking information on the issue from providers, program participant records, and other sources. All investigations will be maintained as confidential. Program participant complaints will be heard promptly and resolved to the extent possible to the satisfaction of both the aggrieved individual and the service provider.

PROCEDURES:

1. The program participant or other individual making a complaint about KVR Program services may communicate either verbally or in writing to the Education, Employment and Supportive Services (EESS) Division - Vice President, Luisa Machuca.
2. The EESS Division Vice President will request from the program participant basic information concerning the complaint such as: name, birth date, dates, location, employee(s) involved, nature of the complaint, and request for action.
3. The EESS Division Vice President will advise the program participant of the intended follow-up plan for his/her complaint to include a plan and means of response.
4. The EESS Division Vice President shall work through the Kawerak Human Resources Department to investigate the complaint and prepare a summary of findings. Additional information may be requested of the program participant as necessary. An employee involved in an investigation of complaint is expected to respond within five working days.
5. The EESS Division Vice President shall respond to the program participant concerning the investigation findings within 30 days, or as agreed to in the follow-up plan, either verbally or in writing.
6. The EESS Division Vice President will review all written communication with the program participant before being mailed.
7. If a satisfactory resolution to the complaint is not reached through the preceding actions, the program participant may appeal in writing to the Kawerak Executive Vice President, Mary David, who will review the record and respond within 10 working days. If no agreement is reached the appeal then goes to the President of Kawerak Inc., Melanie Bahnke.

If the program participant chooses not to handle his or her problem internally, the Alaska Client Assistance Program (CAP) is always available to help any person who has issues with any vocational rehabilitation program. They can be reached toll-free at 1-800-478-1234 or write to them at 330 Arctic Blvd., Suite 103, Anchorage AK 99503.

Applicant Copy – Keep This Page



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Toll Free: 1-800-450-4341 Phone: 907-443-4358 Fax: 907-802-6183

Email: intake@kawerak.org Website: www.kawerak.org

Appeals Process

If the applicant expresses dissatisfaction with the decision for denial of services, the person making the decision will review with him/her the basis for which the decision was made and confirm the validity of facts and the related decision. If error was made or new additional evidence justifies modifying the decision, appropriate adjustments will be made.

If the applicant continues to be dissatisfied after the above review, the applicant has the right to appeal the denial within twenty (15) days of receipt of such denial. A longer period may be allowed if adequate justification supports the applicant's request. The applicant must submit a written request to the Division Vice-President of Kawerak, Inc. requesting a hearing and explaining the reasons for which the hearing is requested. The hearing will be held within ten (5) days. The Division Vice-President of Kawerak, Inc. shall notify the applicant in writing of the date and time of the hearing.

When a hearing is requested, the appropriate program staff will submit a written statement regarding the issue(s), facts and policy upon which the decision was based, to the Division Vice-President. A copy of this statement will be available to the applicant upon request prior to the scheduled hearing.

The applicant may appear in person at the designated time and place of the hearing; however it is the applicant's responsibility to make all arrangements and to pay for any expense that may be incurred. If the applicant cannot appear in person, the hearing will continue to take place. Arrangements may be made for a telephonic hearing.

If a hearing is held and the appealing party does not participate either in person or via the telephone, the appeal shall be decided on the basis of the information contained in the appeal letter and on available written information. Individuals filing an appeal shall be informed of the Vice-President's decision within five (5) days of the hearing and any further avenues of appeal.

If the applicant continues to be dissatisfied after the above review, the applicant has the right to appeal the denial within twenty (10) days of receipt of such denial. A longer period may be allowed if adequate justification supports the applicant's request. The applicant must submit a written request to the President of Kawerak, Inc. of the requesting a hearing and explaining the reasons for which the hearing is requested.

When a hearing is requested, the Division Vice-President will submit a written statement regarding the issue(s), facts and policy upon which the decision was based, to the President. A copy of this statement will be available to the applicant upon request prior to the scheduled hearing.

The applicant may appear in person at the designated time and place of the hearing; however it is the applicant's responsibility to make all arrangements and to pay for any expense that may be incurred. If the applicant cannot appear in person, the hearing will continue to take place. Arrangements may be made for a telephonic hearing.

If a hearing is held and the appealing party does not participate either in person or via the telephone, the appeal shall be decided on the basis of the information contained in the appeal letter and on available written information. Individuals filing an appeal shall be informed of the President's decision within five (5) days of the hearing and any further avenues of appeal.

At any time during the appeals process, the applicant has the right to be represented by someone of his/her choice, including an attorney at his/her expense. Hearings may be re-scheduled under extenuating circumstances. Applicant grievances shall take no longer and be resolved within 60 days.

If the applicant continues to be dissatisfied, the grievant may appeal at the Federal level. Questions about or complaints alleging a violation of the nondiscrimination provisions of WIA section 188 may be directed or mailed directly to: the Director, Civil Rights Center, U.S. Department of Labor, Room N-4123, 200 Constitution Avenue, NW, Washington, D.C. 20210